Michaela Mendelsohn, Ph.D.
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INSURANCE INFORMATION

Primary Insurance Company _____

Address _____

Telephone number _____

ID# _____ Group # _____

Subscriber name _____

Address _____

Telephone number _____ Date of birth _____

Employer _____

Patient relationship to subscriber _____

Secondary Insurance Company _____

Address _____

Telephone number _____

ID# _____ Group # _____

Subscriber name _____

Address _____

Telephone number _____ Date of birth _____

Employer _____

Patient relationship to subscriber _____

Insurance Authorization and Assignment

I hereby authorize Dr. Michaela Mendelsohn to furnish information to my insurance company concerning my treatment, and I hereby assign Dr. Mendelsohn payments for psychological services rendered to me. I understand that I am responsible for any balance not covered by my insurance company

Signature _____ Date _____

Patient Name _____